Arlington INDEPENDENT SCHOOL DISTRICT *More Than a Remarkable Education*

Medical Leave Request Form: Educator Certified

All medical leave request should be made at least 30 days prior to the date leave is set to begin (if possible). Any medical leave approved will require the use of all applicable paid leave time available to the employee.

Name _____ Phone _____

Job Title/Position _____ Hire Date _____

Location/School _____ Employee ID#_____

Date of Request _____ Supervisor/Principal _____

Estimated Leave Start Date _____/_____/_____ Estimated Return to Work Date _____/_____/_____

CHECK ONE	Reason for Absence	Documentation Necessary	Completed by HR Specialist	
			Approved	Denied
	Family Medical Leave (FMLA) Employees who have been with district for at least 12 months, and have worked 1,250 hours in immediate preceding 12 months from date of leave. Limited to medical leave for employee's illness or illness within the employee's family as defined by the Family Medical Leave Act. FMLA runs concurrently with other leaves. Maximum length is 12 work weeks. **Leave Type: □ Continuous □ Intermittent** **Qualifying Event: □Self–Serious Health Condition □Birth/Bonding □Placement-Adoption/Foster Care □Care for a Family Member**	**Medical certification completed by your treating physician** – form is provided by the HR Specialist to the employee when eligibility is determined.		
	Temporary Disability Leave (TDL) Certified employees who are not eligible for FMLA (maximum length is up to calendar 180 days), or who have exhausted FMLA and not medically able to return to work (maximum length is up to 96 calendar days). TDL can only be used for the employee's own serious health condition or birth of a child. TDL must be used continuously. TDL runs concurrently with other leaves. **Qualifying Event: □Self–Serious Health Condition □Birth**	**Medical certification completed by your treating physician** – form is provided by the HR Specialist to the employee when eligibility is determined.		

Employees out for their own medical condition will not be permitted to resume work with the District until a medical release has been received by the HR Benefits Department. If you are out to care for a spouse/parent/child, you must notify the HR Benefits Department and your supervisor of your return date prior to your return.

I understand that the leave I am requesting is an unpaid leave except where use of sick leave, personal days, vacation days, compensatory time, worker's compensation, or paid assault leave are required. Any days taken where leave is unavailable are taken without pay. I understand that the District requires use of all accumulated state sick leave, local sick leave, state personal leave, vacation and compensatory time during leave. I understand that the leave begins on the date specified and shall run concurrently with FMLA and Temporary Disability Leave (TDL) as it applies.

I understand that while I am on FMLA, the District will continue to pay its contribution toward my medical insurance premium for a maximum of twelve weeks as covered under the Family Medical Leave Act, and I am responsible for continued payment of my portion of the medical premium. I understand that while I am on TDL, the District will not continue to pay its contribution toward my medical insurance premium.

I understand that I will not be permitted to resume my position with the District until I provide a doctor's medical release, specifying the date that I am released to return to work with or without reasonable accommodations. I understand that if I do not return to work after I have exhausted my 12 weeks of leave under FMLA and/or Temporary Disability Leave, I may have to resign. I have read and understand District Policy DEC (LOCAL). I attest that the above information is true and correct. I have read and understand the terms and conditions of my leave.

Employee Signature_____ **Date**_____

I acknowledge receiving this notification that the above employee is requesting to take a medical leave of absence under FMLA or Temporary Disability and understand that the request is subject to the approval of the HR Benefits Department.

Principal/Supervisor Signature _____ **Date** _____

The completed form may be faxed (682-867-4651) or scanned & emailed (hrleaves@aisd.net) to the AISD HR Benefits Department

Certification of Health Care Provider for Employee's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I – EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: _____ Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) The medical certification must be returned by _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: _____ Job description (☐ is / ☐ is not) attached.
Employee's regular work schedule: _____
Statement of the employee's essential job functions: _____
_____
(*The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)*

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves *inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: _____

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (___) _____ Fax: (___) _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start: _____ *(mm/dd/yyyy)*

(2) Provide your **best estimate** of how long the condition lasted or will last: _____

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

The patient (☐ was / ☐ will be) seen on the following date(s): _____
_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (*e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: _____

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis*) _____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

(5) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

(6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week)*

_____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)* the employee is able to work: *(e.g., 5 hours/day, up to 25 hours a week)*

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be *not able* to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform *one or more* of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

_____

Signature of Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

ARLINGTON INDEPENDENT SCHOOL DISTRICT
FITNESS-FOR-DUTY CERTIFICATION
(To be submitted prior to reinstatement)

Employee Name: _____Position_____

Campus/Department: _____

Employee's serious health condition which caused him/her to take a medical leave of absence:

_____

_____

Date leave commenced: _____Date leave is set to end: _____

Health Care Provider: I have reviewed the attached job description for this employee. _____ Initial

IS THE EMPLOYEE ABLE TO PERFORM THE ESSENTIAL FUNCTIONS OF HIS/HER JOB? ___YES ___NO

☐ The employee is able to work a full, regular schedule with no restrictions, beginning _____(date)

☐ The employee is able to return to work on a reduced schedule for _____ hours a day
From _____ (date) through _____ (date)

☐ The employee is able to return to work with restrictions from_____ (date) through_____(date).

Please indicate restrictions, if any, below for:

Standing (number of hours): _____ Walking (number of hours): _____

Sitting (number of hours): _____ Lifting (number of pounds): _____

Carrying (number of pounds): _____ Repetitive motion, pushing, pulling: _____

Any other restrictions: _____

_____

_____

Are the Restrictions Permanent? ____ YES ____ NO

_____

Signature of Health Care Provider: _____

Printed Name of Health Care Provider: _____

Date: _____Phone:_____

Please return completed form to the HR Benefits Department via email: hrleaves@aisd.net, Fax: 682-867-4651, or mail: 1203 W. Pioneer Pkwy, Arlington, TX 76013

THIS IS A CONFIDENTIAL RECORD AND IT SHALL BE MAINTAINED AS SUCH

Arlington
INDEPENDENT SCHOOL DISTRICT
More Than a Remarkable Education

HIPAA AUTHORIZATION FORM

Employee's Full Name	**Social Security Number**
Address	**Employee ID Number**
City, State Zip Code	**Date of Birth**
Telephone Number	**Email**

I authorize the use or disclosure of my protected health information as described below.

1. The specific information that should be disclosed is (please give dates of service if possible):

   FMLA and/or Extended leave status updates
2. The following person (or class of persons) is authorized to use or disclose my protected health information:

   Arlington Independent School District Benefits Department
3. The following person (or class of persons) may receive disclosure of protected health information about me:

   Arlington Independent School District Benefits Department

I understand that the use of disclosure of the requested information in this authorization will not result in direct or indirect compensation to the health care provider from a third party.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **AISD Benefits at** hrleaves@aisd.net. I also understand that my revocation is not effective to the extent that the persons I have authorized to use or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and may, in fact, refuse to do so.

I may inspect or copy the protected health information sought to be used or disclosed in this authorization, as permitted by the federal privacy regulations.

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

This authorization expires on _____. If not indicated, it will expire a year from signature date.

_____ _____

Signature of Individual or Personal Representative **Date**

_____

Printed Name

_____

Description of Personal Representative's Authority

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees
- within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor | Wage and Hour Division

WH1420a REV 04/16

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor | Wage and Hour Division

WHD Publication 1420 · Revised February 2013

DEFINITIONS

The term "immediate family" is defined as:

FAMILY

1. Spouse.
2. Son or daughter, including a biological, adopted, or foster child, a son- or daughter-in-law, a stepchild, a legal ward, or a child for whom the employee stands *in loco parentis*.
3. Parent, stepparent, parent-in-law, or other individual who stands *in loco parentis* to the employee.
4. Sibling, stepsibling, and sibling-in-law.
5. Grandparent and grandchild.
6. Any person residing in the employee's household at the time of illness or death.

For purposes of the Family and Medical Leave Act (FMLA), the definitions of spouse, parent, son or daughter, and next of kin are found in DECA(LEGAL).

FAMILY EMERGENCY

The term "family emergency" shall be limited to disasters and life-threatening situations involving the employee or a member of the employee's immediate family.

LEAVE DAY

A "leave day" for purposes of earning, use, or recording of leave shall mean the number of hours per day equivalent to the employee's usual assignment, whether full-time or part-time.

CATASTROPHIC ILLNESS OR INJURY

A catastrophic illness or injury is a severe condition or combination of conditions affecting the mental or physical health of the employee or a member of the employee's immediate family that requires the services of a licensed practitioner for a prolonged period of time and that forces the employee to exhaust all leave time earned by that employee and to lose compensation from the District. Complications resulting from pregnancy shall be treated the same as any other condition.

AVAILABILITY

For salaried employees, the District shall make state personal leave and local leave for the current year available for use at the beginning of the school year.

For all other employees, the District shall make state personal leave for the current year available for use at the beginning of the school year. Local leave shall be made available as earned.

EARNING LOCAL LEAVE

An employee shall not earn any local leave when he or she is in unpaid status. An employee using full or proportionate paid leave shall be considered to be in paid status.

DEDUCTIONS

LEAVE WITHOUT PAY

The District shall not approve paid leave for more leave days than have been accumulated in prior years plus leave currently available. Any unapproved absences or absences beyond accumulated and available paid leave shall result in deductions from the employee's pay.

LEAVE PRORATION

EMPLOYED FOR LESS THAN FULL YEAR

If an employee separates from employment with the District before his or her last duty day of the year, or begins employment after the first duty day, state personal leave and local leave, if applicable, shall be prorated based on the actual time employed.

If an employee separates from employment before the last duty day of the school year, the employee's final paycheck shall be reduced for:

1. State personal leave the employee used beyond his or her pro rata entitlement for the school year; and
2. Local leave a salaried employee used but had not earned as of the date of separation. However, no such adjustment shall be made in the case of death of the employee or if the separation from employment is due to illness or injury certified by a physician, and the employee does not accept other employment.

EMPLOYED FOR FULL YEAR

If a salaried employee uses more local leave than he or she earned and remains employed with the District through his or her last duty day, the District shall deduct the cost of the excess leave days from the employee's pay in accordance with administrative regulations.

RECORDING

Leave shall be recorded as follows:

1. Leave shall be recorded in half-day increments for all employees, whether or not a substitute is employed.
2. If the employee is taking intermittent FMLA leave, leave shall be recorded in one-hour increments.

ORDER OF USE

Available leave shall be used in the order determined by each employee.

CONCURRENT USE OF LEAVE

When an absent employee is eligible for FMLA leave, the District shall designate the absence as FMLA leave.

The District shall require the employee to use temporary disability leave and paid leave, including compensatory time, concurrently with FMLA leave.

An employee receiving workers' compensation income benefits may be eligible for paid or unpaid leave. An absence due to a

work-related injury or illness shall be designated as FMLA leave, temporary disability leave, and/or assault leave, as applicable.

MEDICAL CERTIFICATION

An employee shall submit medical certification of the need for leave if:

1. The employee is absent more than five consecutive workdays because of personal illness or illness in the immediate family;
2. The District requires medical certification due to a questionable pattern of absences or when deemed necessary by the supervisor or Superintendent;
3. The employee requests FMLA leave for the employee's serious health condition or that of a spouse, parent, or child; or
4. The employee requests FMLA leave for military caregiver purposes.

In each case, medical certification shall be made by a health-care provider as defined by the FMLA. [See DECA(LEGAL)]

Note: For District contribution to employee insurance during leave, see CRD(LOCAL).

STATE PERSONAL LEAVE

The Board requires employees to differentiate the manner in which state personal leave is used:

NON-DISCRETIONARY USE

1. Non-discretionary use of leave shall be for the same reasons and in the same manner as state sick leave accumulated before May 30, 1995. [See DEC(LEGAL)]

   Non-discretionary use includes leave related to the birth or placement of a child and taken within the first year after the child's birth, adoption, or foster placement.

DISCRETIONARY USE

2. Discretionary use of leave is at the individual employee's discretion, subject to limitations set out below.

LIMITATIONS

REQUEST FOR LEAVE

The employee shall submit a written request for discretionary use of state personal leave to the immediate supervisor or designee in advance in accordance with administrative regulations. In deciding whether to approve or deny state personal leave, the supervisor or designee shall not seek or consider the reasons for which an employee requests to use leave. The supervisor or designee shall, however, consider the effect of the employee's absence on the educational program or District operations, as well as the availability of substitutes.

LOCAL LEAVE

Professional employees hired prior to the 1988–89 school year shall continue to receive ten local personal leave days per school year.

All other employees shall receive five local personal leave days per school year.

Local leave shall accumulate to a maximum of 50 leave days.

Local leave shall be used according to the terms and conditions of state personal leave. [See STATE PERSONAL LEAVE, above]

SICK LEAVE BANK

The District shall establish a sick leave bank that employees may join through contribution of local leave.

Leave contributed to the bank shall be solely for the use of participating employees. An employee who is a member of the bank may request leave from the bank if the employee experiences a catastrophic illness or injury and has exhausted all paid leave.

If the employee is unable to request leave from the sick leave bank, a member of the employee's family or the employee's supervisor may submit the request.

The Superintendent or designee shall develop regulations for the operation of the sick leave bank that address the following:

1. Membership in the sick leave bank, including the number of days an employee must contribute to become a member;
2. Procedures to request leave from the sick leave bank;
3. The maximum number of days per school year a member employee may receive from the sick leave bank;
4. The committee or administrator authorized to consider requests for leave from the sick leave bank and criteria for granting requests; and
5. Other procedures deemed necessary for the operation of the sick leave bank.

APPEAL

A member may appeal the decision of the sick leave bank committee by writing a letter to the executive officer requesting to appear in person before the committee.

All decisions regarding the sick leave bank may be further appealed in accordance with DGBA(LOCAL), beginning with the Superintendent or designee.

FAMILY AND MEDICAL LEAVE TWELVE-MONTH PERIOD	For purposes of an employee's entitlement to FMLA leave, the 12-month period shall be measured backward from the date an employee uses FMLA leave.
COMBINED LEAVE FOR SPOUSES	If both spouses are employed by the District, the District shall limit FMLA leave for the birth, adoption, or placement of a child, or to care for a parent with a serious health condition, to a combined total of 12 weeks. The District shall limit military caregiver leave to a combined total of 26 weeks. [See DECA(LEGAL)]
INTERMITTENT OR REDUCED SCHEDULE LEAVE	The District shall permit use of intermittent or reduced schedule FMLA leave for the care of a newborn child or for the adoption or placement of a child with the employee. [See DECA(LEGAL) for use of intermittent or reduced schedule leave due to a medical necessity.]
CERTIFICATION OF LEAVE	If an employee requests leave, the employee shall provide certification, as required by FMLA regulations, of the need for leave. [See DECA(LEGAL)]
FITNESS-FOR-DUTY CERTIFICATION	If an employee takes FMLA leave due to the employee's own serious health condition, the employee shall provide, before resuming work, a fitness-for-duty certification. If the District will require certification of the employee's ability to perform essential job functions, the District shall provide a list of essential job functions to the employee with the FMLA designation notice.
END OF SEMESTER LEAVE	If a teacher takes leave near the end of the semester, the District may require the teacher to continue leave until the end of the semester. [See DECA(LEGAL), LEAVE AT THE END OF A SEMESTER]
FAILURE TO RETURN	If, at the expiration of FMLA leave, the employee is able to return to work but chooses not to do so, the District may require reimbursement of premiums paid by the District during the leave. [See DECA(LEGAL), RECOVERY OF BENEFIT COST]
TEMPORARY DISABILITY LEAVE	Any full-time employee whose position requires educator certification by the State Board for Educator Certification or by the District shall be eligible for temporary disability leave. The maximum length of temporary disability leave shall be 180 calendar days. [See DBB(LOCAL) for temporary disability leave placement and DEC(LEGAL) for return to active duty.] An employee's notification of need for extended absence due to the employee's own medical condition shall be forwarded to the Superintendent or designee as a request for temporary disability leave.

WORKERS' COMPENSATION

Note: Workers' compensation is not a form of leave. The workers' compensation law does not require the continuation of the District's contribution to health insurance. [See CRD(LOCAL) regarding payment of insurance contribution during employee absences.]

An absence due to a work-related injury or illness shall be designated as FMLA leave, temporary disability leave, and/or assault leave, as applicable.

An employee eligible for workers' compensation income benefits, and not on assault leave, may elect in writing to use paid leave.

COURT APPEARANCES

Absences due to compliance with a valid subpoena or for jury duty shall be fully compensated by the District and shall not be deducted from the employee's pay or leave balance. The employee shall be required to present documentation of the court appearance or duty and shall be allowed to retain any compensation received.

Absences for court appearances related to an employee's personal business not related to a valid subpoena shall be deducted from the employee's leave or, at the option of the employee, shall be taken as leave without pay.

NEUTRAL ABSENCE CONTROL

If an employee does not return to work after exhausting all available paid and unpaid leave, the District shall provide the employee written notice that he or she no longer has leave available for use. The District shall automatically pursue termination of an employee who has exhausted all available leave, regardless of the reason for the absence [see DF series]. The employee's eligibility for reasonable accommodations, as required by the Americans with Disabilities Act [see DAA(LEGAL)], shall be considered before termination. If terminated, the employee may apply for reemployment with the District.

REIMBURSEMENT FOR LEAVE AT RETIREMENT

Employees hired before January 1, 1985, who intend to retire from the District shall remain eligible for the District's accrued service benefit plan, which includes reimbursement for eligible accrued local leave days.

[See DEG(LOCAL) for a description of the accrued service benefit plan]